UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

United States of America and State of New York, *ex rel*. Edward Lacey,

Plaintiff,

v.

Visiting Nurse Service of New York,

Defendant.

Civil Action No. 14-CV-5739 (AJN)

MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT VISITING NURSE SERVICE OF NEW YORK'S MOTION TO DISMISS

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Relator Edward Lacey respectfully submits this memorandum of law in opposition to the motion by Visiting Nurse Service of New York ("VNSNY") to dismiss the operative complaint in this action ("MTD").[1]

PRELIMINARY STATEMENT

There are two fundamental failures in VNSNY's motion to dismiss. It attacks a very different case than the one actually alleged in the Complaint. And it applies a very different set of legal standards than what the Supreme Court and this Circuit say govern the requirements for pleading a False Claims Act case. When the actual allegations are reviewed under the proper legal framework, there can be little question the Complaint readily crosses the Rule 12(b)(6) and Rule 9(b) thresholds VNSNY so desperately and indiscriminately tries to force out of reach. No amount of VNSNY's factual and legal meanderings can detract from what this case is really about, as the Complaint alleges in meticulous detail -- a healthcare company failing to provide its patients with the critical care their doctors have ordered, it was required to perform and the government paid it to perform. It is this case that VNSNY says nothing about in its motion to dismiss. Yet it is precisely the type of case the False Claims Act was designed to cover.

STATEMENT OF FACTS

The three areas of fraud around which this case centers go to the very core of the critical healthcare services VNSNY is supposed to provide its patients. These are the services physicians have prescribed for the patients they refer to VNSNY. And they are the services Medicare and Medicaid pay VNSNY to provide. Yet, as the allegations in the Complaint set forth in detail, VNSNY has failed to provide these much needed services. VNSNY attempts to downplay the seriousness of these allegations by claiming they are based on Relator's

[1] The operative complaint is the First Amended Complaint for Violations of the Federal and New York State False Claims Act (Corrected) dated July 28, 2016 ("Complaint" or "Compl."). ECF No. 16 (unsealed Sept. 9, 2016).

misapprehension of the Medicare and Medicaid regulations. But it is VNSNY that is misreading the governing regulations and mischaracterizing its abject failure to comply with them.

I. THE CRITICAL IMPORTANCE OF COMPLYING WITH THE PLAN OF CARE

Nowhere is VNSNY's misdirection more apparent than in how it attempts to minimize the significance of the Plan of Care and the absolute requirement that home healthcare companies like VNSNY provide all the visits and services referring physicians prescribe therein. Far from having "no role" in the government's payment calculation as VNSNY insists (MTD 4), complying with the Plan of Care is precisely what the government is paying for. This is evident not only from the central role the Plan of Care plays in the treatment of home healthcare patients. Compl. ¶¶ 18-22. It comes from the Centers for Medicare and Medicaid Services ("CMS") regulations that make complying with the Plan of Care an essential precondition to government payment and to participation in the Medicare and Medicaid programs at all. *Id.* ¶¶ 49-63.

The Plan of Care, which must be signed and periodically reviewed by the referring physician, prescribes the specific healthcare services the home health agency must provide. Compl. ¶ 19. It contains, among other things, the number, timing and frequency of nursing and therapy visits the agency must provide to carry out the prescribed services. *Id*. Medicare and Medicaid pay a predetermined rate under a prospective payment system which covers all the visits and services ordered in the Plan of Care for each 60-day "episode of care" period. *Id.* ¶ 22. The government makes roughly half the payment upfront in response to the home healthcare agency's Request for Anticipated Payment ("RAP"). *Id.* ¶¶ 23-24. It pays the balance at the end of the 60-day episode after the homecare agency submits its final claim for payment. *Id.*

The amount Medicare and Medicaid pay in the final claim may be adjusted upwards or downwards depending on whether the patient requires more or less care than originally prescribed in the Plan of Care. Compl. ¶ 22. But any such changes to the visits and services ordered in the Plan of Care must be signed and dated by the treating physician, effectively creating a new Plan of Care. *Id.* ¶ 19 (citing 42 C.F.R. § 409.43(c)(4)). Thus, VNSNY is wrong to suggest it is free to "deviate" from the mere "projections" in its patient Plans of Care. To the contrary, VNSNY must follow for all its patients (and is paid to follow) the Plan of Care exactly as directed by the physician. *See* 42 C.F.R. § 484.205(b) and § 409.43(c)(4) (noting RAP and final payments "are made in accordance with requirements" that "changes in the plan must be signed and dated by a physician").

The critical importance of following the Plan of Care and how it serves as an essential precondition to Medicare and Medicaid payment and participation is manifest in the CMS regulations and guidance. Indeed, having a physician-signed Plan of Care that specifies the visits and treatments to be provided is one of the central "requirements that must be met for Medicare payments to be made for home health services." 42 C.F.R. § 409.40. *See also* § 409.41(c) (incorporating by reference §§ 409.42(d), and 409.43). So is the accompanying requirement that no changes may be made to the Plan of Care without the physician's signature and approval. 42 C.F.R. § 409.43(c)(4). *See also* 42 C.F.R. § 424.22(a)(1)(iii) (recognizing a physician-signed and periodically reviewed Plan of Care as "a condition for payment of home health services").

VNSNY's motion does not address any of these provisions. Nor does it address (i) the numerous other CMS regulations the Complaint cites on the critical role of the Plan of Care and the obligation of VNSNY to follow it,[2] (ii) the explicit CMS guidance to patients that the home

[2] *See* Compl. ¶¶ 50-54 (citing CMS regulations and interpretations providing: (i) patient must be under Plan of Care that specifies number and frequency of visits; (ii) referring physician must be notified and sign off on any changes to Plan of Care; (iii) expectation that home health agency can meet all healthcare needs of patient; (iv) home health agency must provide services and treatment only as ordered by referring physician and only in accordance with Plan of Care; (v) if home health agency provides fewer visits than the physician orders it has altered the Plan of Care).

health agency must provide all the services ordered in their Plans of Care,[3] or (iii) CMS's enlistment of patients to help fight fraud by reporting "visits that your doctor ordered, but that you didn't get." Compl. ¶ 59. VNSNY does not even address its own highly touted promise to patients and physicians that it will provide all the visits the referring physician has ordered, which it recognizes as "essential" to its role as a home healthcare provider. Compl. ¶¶ 60-61.

The bottom line is that VNSNY is incorrect in its overarching assertion that the Plan of Care is not "an unchangeable edict." MTD 10. That is exactly what it is, unless and until the treating physician dictates otherwise. There obviously may be legitimate reasons for a home health patient to receive fewer visits and services than prescribed in the original Plan of Care. MTD 23 n.13 (citing early recovery, death, move, etc.). But as CMS makes clear in its regulations and guidance, none of them include the unilateral decision by the home health agency to ignore the doctor's orders or the requirement of physician sign-off to change the Plan of Care -- as VNSNY has done here.[4]

II. VNSNY'S PERVASIVE FAILURE TO COMPLY WITH THE PLAN OF CARE

Despite the critical importance of complying with the Plan of Care, VNSNY has intentionally failed to do so for tens of thousands of its patients. Compl. ¶ 27. These failures are not slight "deviations" from the Plan of Care or a failure to provide just some of the services the referring physician "contemplated" or "anticipated" for these patients. MTD 7-8, 11. Rather, they are VNSNY purposely providing only a fraction of the critical care services the referring physicians have ordered and VNSNY is required (and has promised) to provide. And they draw from the company's mandatory policy of accepting all referrals even when it knows it does not have the capacity to handle them. Compl. ¶ 28.

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[3] *See* Compl. ¶¶ 58-59 (citing various CMS materials providing that home health agency: (i) "must provide [] all the home care listed in your plan of care;" and (ii) "must give you or arrange for all the home healthcare listed in your plan of care, . . . and only change it with your doctor's approval.")

[4] The United States Statement of Interest in *Prather* VNSNY cites has nothing to do with this obligation to comply with the Plan of Care. MTD 11. That decision did not even involve this issue. It involved whether a physician's certification of medical necessity was a defense to a claim of non-medically necessary services. The government and Sixth Circuit said it was not a defense because the certification is a forward-looking projection of need that does not account for changes in the patient's health. The Plan of Care is very different from this kind of certification. It cannot be changed without physician approval and sign-off and must be followed by the home health agency. There is no support in *Prather* for VNSNY's contrivance that it may disregard the Plan of Care as it sees fit.

The Complaint provides detailed allegations of this "accept all referrals" policy and how it has been strictly imposed and rigidly enforced by VNSNY's senior management. *See* Compl. ¶¶ 29-42 (identifying the who/what/where/when particulars of multiple VNSNY executive meetings where the policy was discussed and complaints were raised about VNSNY failing its patients in considerable numbers). The Complaint provides from many of the executives attending these meetings direct quotes on the extent of VNSNY's systematic failure to follow the patient Plans of Care and the serious harm it has caused patients.[5] And the Complaint cites to numerous internal VNSNY reports which detail specific examples of the scope of this failure.[6]

Perhaps most vividly, the Complaint cites to numerous patient-specific examples of VNSNY's failure to provide its patients the critical care ordered by their physicians. Compl. ¶¶ 44-45. These examples show patients with serious medical conditions (amputation, mastectomy, kidney transplant, knee replacement, congestive heart failure, diabetes, etc.) in need of vital nursing and therapy care. Yet, for each of them, and for tens of thousands of similarly situated patients, VNSNY has wholly ignored the doctor's orders in the Plan of Care. *Id.* ¶¶ 44-46.

In none of these cases did VNSNY notify and receive sign-off from the referring physician of VNSNY's unilateral decision to so drastically alter the Plan of Care. Compl. ¶ 47. And in no instance did VNSNY disclose to the government in connection with either its RAP or final claim for payment that it did not provide -- and never intended to provide -- a sizeable portion (in many cases, the vast majority) of the visits and services ordered in the Plan of Care. *Id.* Despite this blanket failure to follow the Plan of Care -- and the resulting pain, suffering and needless re-hospitalization it has caused for so many of its patients -- VNSNY has billed and received episodic payments from Medicare and Medicaid anyway. *Id.* ¶¶ 46, 48.

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[5] *See, e.g.* Compl. ¶ 37 ("there has been an explosion of complaints from hospitals, doctors, and patients"); ¶ 40 (referring to the company as "the 'No' Visiting Nurse Service"); ¶ 41 ("one of us has to speak up"); ¶ 42 (the company is "out of compliance" and "unable to provide safe care and services"); (referring to a "grave situation" with "complaints and threats from physicians, patients, family members, and hospitals").

[6] *See* Compl. ¶ 33 (citing reports detailing thousands of patients for which VNSNY failed to provide any of the therapy visits prescribed by their treating physicians); ¶ 34 (citing report detailing patients who had not received any visits prescribed during the covered period); ¶ 35 (citing same).

Contrary to VNSNY's contention, Relator has not misconstrued the episodic payment system at issue for a fee-for-service system where the government pays on a per-hour or per-visit basis. MTD 1-2. VNSNY developed its "accept all referrals" scheme precisely because of the episodic payment system which allows VNSNY to increase net revenues by maximizing the number of episodic payments it receives under Medicare and Medicaid while minimizing the amount of services it provides. Compl. ¶¶ 28, 62. Notably, the government specifically cautioned against this very type of misconduct -- providing fewer services than required -- when it moved Medicare from a fee-for-service to episodic payment system for home healthcare.[7]

III. VNSNY'S FALSIFIED NURSE AND THERAPY VISITS

One of the inevitable consequences of VNSNY's "accept all referrals" scheme is the inability of VNSNY nurses and therapists to provide their patients with a sizeable portion of the visits and services their physicians have ordered. In an effort to conceal this failure, many nurses and therapists falsify their time and service records. Compl. ¶ 65. They obviously benefit from this misconduct because it inflates the number of visits and hours on which their compensation is

[7] *See* July 2002 GAO Report at 1 ("Oversight of [home health agencies] has become even more important since the implementation of a new prospective payment system . . . provides an incentive to reduce services in order to increase net revenues."), available at http://www.gao.gov/assets/240/235217.pdf; September 2000 HHS OIG Report at 14 ("The introduction of the Prospective Payment System . . . could create or increase the incentive on the part of some home health agencies to shortchange Medicare home health beneficiaries in the amount and intensity of care provided."), available at https://oig.hhs.gov/oei/reports/oei-02-99-00532.pdf.

based. *Id.* ¶ 66. But VNSNY also benefits by receiving Medicare and Medicaid reimbursement for visits and services that did not happen or involve the type or length of care reported. *Id.*

As evidence of this widespread falsification, the Complaint points to VNSNY's visit verification system which is supposed to verify that nursing and therapy visits VNSNY bills to Medicare and Medicaid actually occurred, including what services were provided and the length of each visit. Compl. ¶ 64. What this system shows instead is a pervasive pattern of nurses and therapists reporting, and VNSNY billing for, visits and services they never provided. *Id.* ¶¶ 67-74. The Complaint details scores of patient and nurse-specific examples of VNSNY staff logging visits too numerous or too fleeting to have actually occurred by any reasonably objective measure, or by VNSNY's own standard measure of 6 visits per day at 37 minutes per visit.[8]

VNSNY tries to mischaracterize this claim as merely a failure to adhere to internal visit verification policies. MTD 1, 5, 11-13, 21. That is not what Relator is alleging here. Relator is alleging these visits and services were never provided and that VNSNY billed Medicare and Medicaid for them anyway. Compl. ¶¶ 71, 74, 97-98, 104-05. How VNSNY nurses and therapists have completed their Visit Reports is thus not the alleged violation (though their extensive failure to follow the verification requirements certainly renders false VNSNY's certification the billing information it submits is accurate and complete). *Id.* ¶ 71. Rather, the Visit Reports are the evidence that VNSNY is billing for visits and services that never happened.

IV. VNSNY'S IMPROPER BILLINGS FOR HOME HEALTH AIDE VISITS

Relator's third claim is that VNSNY has billed Medicare and Medicaid for home health aide services it has not provided, have not been properly supervised or have otherwise not complied with Medicare and Medicaid regulations. Compl. ¶¶ 75-91. More specifically, VNSNY has billed Medicare for custodial care or housekeeping services (cleaning, cooking, shopping and laundry), knowing that Medicare does not cover these services. Compl. ¶¶ 75-81. It has double-billed Medicare and Medicaid on home health aide services for those patients dually eligible under both programs. *Id.* ¶¶ 82-88. And it has failed to provide the required oversight of home health aides to ensure safe and effective patient care. *Id.* ¶¶ 89-91. For each of these allegations, the Complaint details specific internal reports, patient-specific examples, internal company discussions, and company billing data evidencing the alleged fraud.[9]

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[8] Compl. ¶ 67. *See, e.g, id.* ¶ 68 (showing impossibly high annual visit counts, exceeding VNSNY standard by several thousand visits); ¶ 70 (showing impossibly high daily visit counts, more than triple the VNSNY standard); (showing impossibly short visit durations, far below the VNSNY standard); (showing geographically dispersed visits within minutes of each other); (showing visits lasting 3 minutes or less); ¶ 72 (showing failure to obtain required patient verification for vast majority of visits, and in some cases all of them).

ARGUMENT

I. THE BROAD AND EXPANSIVE REACH OF THE FALSE CLAIMS ACT

The False Claims Act was enacted in 1863 by President Lincoln to combat widespread fraud by companies selling rancid food, ailing mules and defective weapons to the Union Army during the Civil War. From the outset, and through several amendments to increase the scope and reach of the statute, both Congress and the Supreme Court have repeatedly highlighted the two key features of the law. First, it is to be applied "expansively, meaning to reach all types of fraud, without qualification, that might result in financial loss to the government." *Cook Cnty. v. U.S. ex rel. Chandler*, 538 U.S. 119, 129 (2003) (internal quotes and cite omitted).

Second, whistleblowers are to be strongly encouraged to supplement the government's limited resources to combat fraud. Under the statute's *qui tam* provisions, whistleblowers are entitled to a portion of any government recovery, an award that increases when the government does not intervene. 31 U.S.C. § 3730(d). In providing these strong financial incentives, which

[9] *See* Compl. ¶¶ 77-78 (citing internal reports with patient-specific examples of VNSNY re-coding non-reimbursable custodial care services as reimbursable personal care services); ¶¶ 79, 81 (citing internal discussions on alleged fraud); ¶ 85 (citing company data on disproportionate home health aide billings to Medicaid); ¶¶ 87-88 (citing internal discussion and audit on alleged fraud); ¶ 90 (citing internal report with patient-specific examples of VNSNY failing to comply with home health aide supervision requirements).

were significantly increased by 1986 amendments to the statute, Congress made clear its view that whistleblowers play a critical role in False Claims Act enforcement. Earlier this month, the Supreme Court reaffirmed yet again this essential role played by whistleblowers. *See State Farm Fire & Cas. Co. v. U.S. ex rel. Rigsby*, 196 L. Ed. 2d 340, 348 (2016) (1986 reforms designed to "encourage more private enforcement" because lack of government resources was "perhaps the most serious problem plaguing effective enforcement") (internal quotes and cites omitted).[10]

When evaluating claims under the False Claims Act, the Supreme Court has repeatedly deferred to these twin goals and "consistently refused to accept a rigid, restrictive reading." *U.S. v. Neifert-White Co.*, 390 U.S. 228, 232 (1968). In its motion, however, VNSNY takes no account of these driving features of the statute. In fact, VNSNY argues for an application of the statute that would seriously undercut them. It would unduly narrow the theories of False Claims Act liability under which home healthcare cases could be brought. It would make significantly more demanding the statute's materiality standard just reaffirmed by the Supreme Court. And it would impose an overly rigorous pleading standard that elevates the plausibility threshold to one of probability, and that goes well beyond the detail required under Rule 9(b).

II. THE RELEVANT RULE 12(b)(6) STANDARD

Under Rule 12(b)(6), courts must "constru[e] the complaint liberally, accepting all factual allegations . . . as true, and drawing all reasonable inferences in the plaintiff's favor." *Chambers v. Time Warner, Inc.*, 282 F.3d 147, 152 (2d Cir. 2002). *See also Ji Li v. Ichiro Sushi, Inc.*, 2016 U.S. Dist. LEXIS 41894, *7 (S.D.N.Y. Mar. 29, 2016) (Nathan, J.) (must "accept as true all facts alleged in the complaint" and "draw all reasonable inferences in favor of the plaintiff"). Under the *Twombly/Iqbal* plausibility standard, the complaint must contain more than "[t]hreadbare recitals," "conclusory statements" or a "sheer possibility" of the challenged conduct. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). It must contain "factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.*

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[10] *See also* H.R. Rep. No. 660, 99th Cong., 2d Sess. 22 (1986) (purpose of *qui tam* provisions to encourage "private individuals who are aware of fraud being perpetrated against the Government to bring such information forward"); *U.S. ex rel. Doghramji v. Cmty. Health Sys., Inc.* 2016 U.S. App. LEXIS 21155, at *30 (6th Cir. 2016) (Stranch, J., concurring) ("[R]elators . . . play a vital role in rooting out healthcare fraud and obtaining recovery of the public monies that were intended to be spent for providing healthcare to veterans and poor, elderly, and disabled citizens.").

This does not impose a "probability requirement." *Id.* Nor does it require the allegations to "rule out the possibility of [lawful] action, as would be required at . . . summary judgment." *Anderson News, L.L.C. v. Am. Media, Inc.*, 680 F.3d 162, 184 (2d Cir. 2012). The plausibility threshold can be satisfied "even if it strikes a savvy judge that actual proof of those facts is improbable, and that a recovery is very remote and unlikely." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007) (internal quotes and cite omitted). It likewise can be satisfied by "factual allegations that are sufficient to 'give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.'" *Anderson*, 680 F.3d at 182 (quoting *Twombly*, 550 U.S. at 555). The ultimate question "is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Todd v. Exxon Corp.*, 275 F.3d 191, 198 (2d Cir. 2001). A court may not dismiss a case "unless it appears beyond doubt that the plaintiff can prove no set of facts which would entitle him or her to relief." *Chambers*, 282 F.3d at 152.

III. THE COMPLAINT READILY SATISFIES RULE 12(b)(6) WITH ITS DETAILED ALLEGATIONS OF MATERIAL FALSITY

The False Claims Act imposes civil liability on any person who (i) "knowingly presents, or causes to be presented" to the government "a false or fraudulent claim for payment or approval," or (ii) "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A&B). VNSNY argues the Complaint fails to plead facts supporting the existence of any false or fraudulent claims. But it does so by rewriting or ignoring key allegations in the Complaint and inventing new allegations to color the Court's view of the underlying merits of this action.[11]

VNSNY also attempts to shoehorn this case into only one theory of False Claims Act liability -- implied false certification. MTD 8-11. While that theory of liability is certainly applicable here, it is not the only one that applies. This case also presents the "archetypal FCA claim" of factual falsity through VNSNY's billing and the government's paying for services VNSNY never actually provided. *Bishop*, 823 F.3d at 43. It likewise presents a classic case of fraudulent inducement through VNSNY's misrepresentations and omissions to the government, referring physicians, and patients regarding its supposedly intended compliance with the patient Plans of Care. VNSNY's factual and legal maneuverings here have no place in a motion to dismiss (or even on summary judgment) and do nothing to undermine the clear application of the False Claims Act to the fraudulent conduct and false claims at issue here.

A. Relator's Plan of Care Claim Readily Satisfies Rule 12(b)(6)

1. *Relator's Plan of Care Claim Falls Within Both the "Factually False" and "Fraudulent Inducement" Theories of Liability*

As discussed above, VNSNY's challenge to Relator's Plan of Care claim is based on a fundamental misconstruction of how the Plan of Care operates and the central role it plays in carrying out the medical decisions of the treating physician. *Supra* pp. 2-4. VNSNY also wholly mischaracterizes the extent of VNSNY's rampant and extreme failures to comply with its patient Plans of Care. *Supra* pp. 4-6. These are not the one-off instances of modest, justified and physician-approved departures from the Plan of Care that VNSNY tries to conjure. They are part

[11] MTD 7-18. VNSNY only challenges the sufficiency of the allegations relating to the falsity element of Relator's False Claims Act claims. It does not challenge the other elements of Relator's claims, including (i) the existence of a claim for payment, or false record material to such a claim, (ii) to the government, (iii) seeking payment and (iv) and knowing the claim or record is false. *See Bishop v. Wells Fargo & Co.*, 823 F.3d 35, 43 (2d Cir. 2016).

of a system-wide, corporate-driven policy of ignoring the critical care orders of the treating physician for the singular purpose of maximizing government reimbursement. Compl. ¶¶ 28, 62.

Under the facts as actually alleged and the Plan of Care as it truly operates, the Complaint presents "the archetypal FCA claim involv[ing] a factually false request for payment from the government, as when a contractor delivers a box of sawdust to the military but bills for a shipment of guns." *Bishop*, 823 F.3d at 43. *See also U.S. ex rel. Mikes v. Straus*, 274 F.3d 687, 697 (2d Cir. 2001) ("factually false" claims involve "an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided"), *abrogated on other grounds by Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, 136 S. Ct. 1989 (2016).

For each of its patients, for each of their episodes of care, VNSNY is supposed to provide the visits and services the doctors have ordered at the timing and frequency they have ordered them. What VNSNY is providing instead for tens of thousands of its patients is some small subset of these visits and services and with a timing and frequency it unilaterally sets. In doing so, VNSNY is not only defying the doctor's orders. It is violating the many regulations CMS has established to ensure it is the treating physician, not the home healthcare agency, who determines the best course and manner of treatment for the patient. *Supra* pp. 2-4.

In this way, what VNSNY is providing here is no different than the box of sawdust or the "procedure with no medical value" which this Circuit has found supports a violation of the False Claims Act "irrespective of any certification." *Mikes*, 274 F.3d at 702. It likewise closely resembles the many other instances where courts have sustained "factually false" claims based on the government's payment for goods or services not actually provided.[12] As Congress has made clear, "a false claim may take many forms," but what they all tend to have in common is that they involve "a claim for goods or services not provided, or provided in violation of contract terms, specification, statute, or regulation." S. Rep. No. 99-345, at 9 (1986). Relator's allegations of VNSNY's fraud in failing to follow the Plan of Care fit precisely into this paradigm.[13]

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[12] *See, e.g., U.S. v. Bornstein*, 423 U.S. 303, 307 (1976) (sale of tubes falsely marked as having required quality); *N.Y. ex rel. Khurana v. Spherion Corp.*, 2016 U.S. Dist. LEXIS 156572, *43-44 (S.D.N.Y. 2016) (finding "plausible theory of factual falsity" raised by allegations that defendant "billed for certain services it did not actually provide"); *U.S. v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770, 779 (7th Cir. 2016) (defendants "misused a billing code

The allegations also fit into the well-accepted "fraudulent inducement" theory of False Claims Act liability where the misrepresentations or omissions were material to the government's decision to contract in the first place.[14] As the Complaint makes clear, if patients and their treating physicians knew that -- despite VNSNY's much ballyhooed promise to provide "all the services your doctor has ordered" (Compl. ¶ 60) -- VNSNY had no intention of following the Plan of Care, they never would have selected VNSNY in the first place. *Id.* ¶ 63. Nor would the government have provided payment (either RAP or final) had it known VNSNY intended to (and did) so blatantly disregard the Plan of Care and all the rules mandating its compliance. *Id.*

2. *Relator's Plan of Care Claim Also Falls Within the "Implied Certification" Theory of Liability Under Escobar*

Thus, VNSNY's exclusive reliance on the *Escobar* implied certification test is entirely misplaced. MTD 8-11. The Complaint supports a False Claims Act violation "irrespective of any certification" -- express, implied or otherwise. *Mikes*, 274 F.3d at 702. Nevertheless, the allegations readily support an implied false certification theory of liability too. Indeed,

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and falsely represented that a certain treatment was given by certain medical staff"); *U.S. v. Mackby*, 261 F.3d 821, 826-27 (9th Cir. 2001) (seller did not actually render or supervise services provided); *U.S. ex rel. Compton v. Midwest Specialties, Inc.*, 142 F.3d 296, 302 and n.4 (6th Cir. 1998) (sale of Jeep brake kits not properly tested).

[13] That payment for home health services are made on an episodic rather than pay-per-visit basis, as VNSNY takes pains to point out (MTD 1-2, 5, 11, 15, 17, 22), only reinforces that the government is paying for complying with the entire Plan of Care, not for individual visits wholly detached from whether they follow the doctor's treatment plan.

[14] *See, e.g.*, *Neifert-White*, 390 U.S. at 232 (the statute covers any action which has the "effect of inducing the Government immediately to part with money"); *U.S. ex rel. Feldman v. van Gorp*, 697 F.3d 78, 91 (2d Cir. 2012) ("If the government made payment based on a false statement, then that is enough for liability in an FCA case," such as when a "false statement comes at the beginning of a contractual relationship…as it would be in a fraudulent inducement case."); *U.S. v. Wells Fargo Bank, N.A.*, 972 F. Supp. 2d 593, 623 (S.D.N.Y. 2013) ("courts have repeatedly held that the use of fraudulent information to induce the Government to . . . contract constitutes a false claim under the FCA") (internal quotes and cite omitted).

VNSNY's failure to disclose to the government its noncompliance with the Plan of Care -- or that it had no intention of following the Plan of Care -- "fall[s] squarely within the . . . half-truths" the Supreme Court was trying to target in *Escobar*. 136 S. Ct. at 2000.

VNSNY attempts to avoid the clear application of that case to this one by asserting a supposed "threshold" failure of the Complaint to "even allege what the *claims* are . . . or at what point in Medicare's multi-step billing process" VNSNY submitted them. MTD 9 (emphasis in original). Yet the Complaint repeatedly points to the two distinct claims at issue, which VNSNY submits as part of every patient's 60-day episode of care -- the RAP at the start of the episode; the final claim at the end. Compl. ¶¶ 23-24. *See also id.* ¶¶ 47, 63, 97-98, 104-05 (citing VNSNY failure to disclose Plan of Care violations in both RAP and final payment claims).

VNSNY likewise pretends these two types of claims lack the "specific representations" VNSNY says *Escobar* requires in making out an implied certification claim. MTD 8-9. There is no such requirement.[15] Even if there were, these claims contain the very type of "representations" that were on the claims at issue in *Escobar*. Just like the payment codes in *Escobar* for counseling services the defendant submitted "without disclosing [defendant's] many violations of basic staff and licensing requirements," VNSNY's RAP and final claims contain a litany of payment codes which VNSNY submitted without disclosing its intended or actual violations of the strict Plan of Care requirements.[16] VNSNY is thus clearly mistaken in suggesting the RAP and final claims it submits "merely request payment" and nothing more. *Id.*

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[15] As the United States points out in two recent Statements of Interest it filed in this Circuit, *Escobar* does not require a specific representation as any prerequisite for bringing an implied certification claim because (i) the Supreme Court expressly declined to address the question, and (ii) the Second Circuit in *Mikes* did address the question and found the mere submission of a claim for payment enough. *U.S. ex rel. Wood v. Allergan, Inc.*, No. 10 Civ. 5645 (S.D.N.Y. Dec. 15, 2016), ECF No. 91 at 2-10; *U.S. ex rel. Panarello v. Kaplan Early Learning Co.*, No. 11-CV-353 (W.D.N.Y. October 7, 2016), ECF No. 93, at 5-6.

[16] 136 S. Ct. at 2000. As set forth in the CMS Medicare Claims Processing Manual, Chapter 10 - Home Health Agency Billing, on which VNSNY so heavily relies (MTD 3-4), these codes for the RAP and/or final claim include: (i) *Type of Bill Code*, which represents the RAP and final claim are being submitted for home health services

VNSNY's attack on the Complaint's detailed materiality allegations is equally fanciful. MTD 9-11. It is entirely premised on VNSNY's wholesale disregard of the numerous allegations on the critical function of the Plan of Care and its role as an essential precondition to Medicare and Medicaid payment and participation. *Supra* pp. 2-4. VNSNY's pervasive failure -- to provide its patients the vital healthcare services their doctors have ordered, VNSNY has promised, and the regulations require -- shares nothing in common with the "garden-variety breaches" or "insignificant regulatory [] violations" *Escobar* cautions against and which VNSNY strains to portray here.[17] That is why CMS routinely expels from the Medicare program home health agencies that fail to follow their patient Plans of Care. Compl. ¶¶ 55-57.

VNSNY attempts to distinguish these termination cases by arguing they involved more egregious misbehavior. MTD 10, n.7. Once again, VNSNY is rewriting or ignoring the detailed allegations in the Complaint of VNSNY forsaking scores of patients with the most serious of life-threatening diseases and conditions. Compl. ¶¶ 44-48.[18] VNSNY is equally off-base in its effort to dismiss the relevance of these eligibility decisions by arguing they didn't address the

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provided under a Plan of Care (contained on RAP and final claim); (ii) *Revenue Code*, which represents all services (nursing, therapy, home health aide) provided to the patient in line item detail, including the number of 15 minute increments for each service (contained on final claim); and (iii) numerous other codes representing the medical condition and required treatment of the patient, including *Treatment Authorization Code, Health Insurance Prospective Payment System Code, International Classification of Diseases Code, Condition Code,* and *Patient Status Code*. *See* Manual §§ 10.1.7-12; 40.1-2. VNSNY in fact goes out of its way to highlight "the visit information submitted in line-item detail on the claim for the episode." MTD 4 (quoting Manual § 10.1.19.1).

[17] 136 S. Ct. at 2003-04. VNSNY's attempt to force this case outside *Escobar* is particularly far-fetched given the CMS rule that RAP and final payments be made in accordance with the Plan of Care requirements, including the requirement that "[a]ny changes in the plan must be signed and dated by a physician." *See* 42 C.F.R. § 484.205(b)(1&2) (citing to Plan of Care requirements of § 409.43(c), with specific physician sign-off requirement at § 409.43(c)(4)). Perhaps even more tellingly, these same provisions highlight that while the RAP is not considered a formal Medicare claim, it is a "claim" for purposes of the False Claims Act. § 409.43(c)(2).

[18] If anything, the misconduct and patient harm at issue here -- patient amputation, 65 rehab/nursing visits ordered, 5 provided; patient mastectomy, 52 rehab/nursing visits ordered, 5 provided; patient kidney transplant, 57 rehab/nursing visits ordered, 6 provided; etc. -- is significantly more egregious than in these termination cases. Compl. ¶ 44. *See, e.g., Techota LLC v. CMS,* 2009 HHSDAB LEXIS 11, at *12-13 (patient wound, 2 nursing visits missed out of 6 ordered). VNSNY's further attempt to distinguish these decisions as "inapposite" because they involved failures to comply with "numerous" Medicare requirements is similarly inapt. MTD 10, n.7. VNSNY also has violated numerous Medicare requirements with its extensive failures to follow its patient Plans of Care. *Supra* pp. 4-6. These termination decisions were driven by the very same violations.

question of government reimbursement, recoupment or "indeed any conditions of payment whatsoever." MTD 10, n.7. This is just the type of rigid materiality test *Escobar* rejected. Otherwise, the Court warned, it would lead to the perverse result VNSNY is suggesting should apply here, where violating a condition of payment could be actionable but violating a "condition of eligibility to even participate in a federal program . . . would not." 136 S. Ct. at 2002.

What the Supreme Court fashioned instead, as the United States articulated to this Court in a Statement of Interest it filed in another matter just a few weeks ago, is a "holistic assessment of the tendency or capacity of the undisclosed violation to affect the Government decision-maker." *U.S. ex rel. Ortiz v. Mt. Sinai Hosp.*, No. 13 Civ. 4735 (S.D.N.Y. Dec. 2, 2016), ECF No. 212, at 3. With no one factor being dispositive, this could include "whether the requirement violated is expressly labeled as a condition of payment, . . . is significant or minor or insubstantial, . . . goes to the essence of the bargain, . . . and how the Government has treated similar violations." *Id.* (citing *Escobar*, 136 S. Ct. at 2003-04) (internal quotes omitted). *See Escobar*, 842 F.3d 103 (1st Cir. 2016) (on remand, applying "holistic approach").

At this motion to dismiss stage, Relator's allegations clearly support the materiality of VNSNY's Plan of Care violations under each of these factors or any other conceivable factor.[19] That VNSNY argues otherwise; that VNSNY's intentional failure to provide patients with the vast majority of critical care services their physicians have ordered would *as a matter of law* have absolutely no "tendency to influence, or be capable of influencing" the government's payment decision -- shows how far VNSNY is willing to go in its misapplication of *Escobar.*[20]

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[19] It is a condition of payment, notwithstanding VNSNY's repeated protestations. *Supra* p. 3 (citing 42 C.F.R. §§ 409.40, 409.41(c), 409.42(d), 409.43(c)(4) and 424.22(a)(1)(iii)). VNSNY's violations are substantial in magnitude and scope. *Supra* pp. 4-6. They go to the essence of what the government is paying for. *Supra* pp. 2-4. And CMS has expelled home health agencies for engaging in violations far less severe and pervasive than here. *Supra* p. 15.

[20] 136 S. Ct. at 2002. As the United States stressed in its recent *Ortiz* Statement of Interest, *Escobar* reaffirmed that the proper test for determining materiality is whether the misconduct has "a natural tendency to influence, or [is]

B. Relator's Falsified Visits Claim Readily Satisfies Rule 12(b)(6)

VNSNY has taken the same creative pen to Relator's falsified visit claim. Indeed, the crux of VNSNY's challenge doesn't even address the falsified visits at issue. Instead, VNSNY takes on an entirely different claim; that it has not complied with its internal visit verification requirements. MTD 11-13. That is not what the Complaint is challenging here. It is challenging that VNSNY never provided these visits and services but billed and received payment for them anyway. *Supra* pp. 6-7. Even under VNSNY's slanted view of the statute, it cannot possibly argue that billing for services not provided somehow falls outside the False Claims Act.

Thus VNSNY's cases on violations of internal company policies have nothing to do with what the Complaint actually alleges.[21] VNSNY makes an equally gratuitous stretch in its reliance on *Iqbal* to devise "alternative explanations" for the impossibly short visits and high daily visit counts so many of its nurses and therapists have reported. MTD 13-14 (identifying "densely populated neighborhoods," "clustered apartments," "institutional and congregate care settings," "routine and quickly completed [visits]," and "sloppy or lax record-keeping"). *Iqbal* did not give license to this kind of invention, and the Second Circuit has outright rejected it.[22]

In *Anderson News*, the defendant raised the same kind of alternative explanations as VNSNY conjures here to challenge the plausibility of plaintiff's allegations of conspiracy. While the district court dismissed the case based on these innocuous alternative possibilities, the

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capable of influencing," and does not require a showing "that a claim would not actually have been paid or even that it would 'likely' not have been paid." *Ortiz* Stmt. 1-2.

[21] MTD 12 (citing cases). VNSNY also inexplicably cites to *Mikes* and *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 625 F.3d 262 (5th Cir. 2010), to suggest only violations of conditions of payment support an implied false certification claim. MTD 12. As already discussed, and as VNSNY appears to acknowledge in other sections of its brief (*id.* at 9), *Escobar* explicitly rejected this overly restrictive limitation.

[22] VNSNY finds no support for its "alternative explanation" theory in the three cases it cites. MTD 14. In *Pantoja v. Banco Popular*, 545 F. App'x 47, 49 (2d Cir. 2013), the plaintiff's insurance claim lacked "facial plausibility" because it "alleged damage predating the policy." The case had nothing to do with competing explanations for any alleged misconduct. VNSNY's reliance on *Mikes* and *Omnicare* is similarly misplaced. The portion of those cases VNSNY cites deal with intent, not falsity, with each merely finding the requisite intent not satisfied by negligence.

Second Circuit vacated and remanded the decision finding the district court's "plausibility inquiry [] misdirected." 680 F.3d at 189. The Court reasoned as follows:

> Because plausibility is a standard lower than probability, a given set of actions may well be subject to diverging interpretations, each of which is plausible. . . . [But t]he question at the pleading stage is not whether there is a plausible alternative to the plaintiff's theory; the question is whether there are sufficient factual allegations to make the complaint's claim plausible. [*Id.* at 184, 189.]

The Court concluded that while it believed the defendant's proffered alternative explanation was in fact the most plausible scenario, "on a Rule 12(b)(6) motion it is not the province of the court to dismiss the complaint on the basis of the court's choice among plausible alternatives."[23]

In any event, VNSNY's alternative imaginings are not only improper on a motion to dismiss, they are not even plausible. No amount of population density, apartment clustering, insulin injections or sloppy record-keeping -- as VNSNY would have it (MTD 14) -- can reasonably explain away the allegations of impossible visit counts and durations the Complaint lays out in detail down to the nurse, patient, street, day, hour and minute. *Supra* p. 7. Nor can they be squared with the broader allegations of the company's "accept all referrals" policy and the numerous instances where senior executives acknowledged at meetings with Relator the company's widespread failure to provide patients the treatment their doctors ordered. *Supra* pp. 4-6. But again, how these competing "visions" of VNSNY's misconduct weigh out is a subject for summary judgment and trial, not VNSNY's challenge to the sufficiency of the pleadings.[24]

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[23] *Id.* at 190. *See also In re Commodity Exch. Inc.*, 2016 U.S. Dist. LEXIS 137834, at *27 (S.D.N.Y. Oct. 3, 2016) ("*Iqbal* does not require the complaint to allege facts which can have no conceivable other explanation, no matter how improbable that explanation may be.") (internal quotes and cite omitted); *Gelboim v. Bank of Am. Corp.*, 823 F.3d 759, 782 (2d Cir. 2016) ("at the motion-to-dismiss stage, [plaintiff] must only put forth sufficient factual matter to plausibly suggest an inference of [misconduct], *even if* the facts are susceptible to an equally likely interpretation") (emphasis in original); *SEC v. Egan*, 994 F. Supp. 2d 558, 563 (S.D.N.Y. 2014) ("'[T]he choice between two plausible inferences that may be drawn from factual allegations is not a choice to be made by the court on a Rule 12(b)(6) motion.") (quoting *Anderson*).

[24] VNSNY also seems to argue that even conceding it included in its claims for payment falsified visit information, this still would not be enough without allegations the government as a result paid more. MTD 15-16. VNSNY cites no authority for this outlandish proposition. There is none. It ignores the materiality test *Escobar* just reaffirmed.

C. Relator's Home Health Aide Visits Claim Readily Satisfies Rule 12(b)(6)

VNSNY's challenge to Relator's home health aide claims is subject to the same machinations. *First*, with the custodial care claim, VNSNY contends Relator is "flatly wrong" in "suggesting a bright-line rule that custodial care services are non-reimbursable under Medicare." MTD 16. But 42 C.F.R. § 409.49(d), which explicitly excludes these services from coverage, presents just such a rule.[25] VNSNY further argues it would receive no benefit from these fraudulent billings under Medicare's episodic payment system. MTD 17. Aside from ignoring the Complaint (¶¶ 76-78), VNSNY again sidesteps the ultimate question of whether these falsified billings would have been material to the government's payment decision. As the Complaint lays out, they clearly would have been. *See, e.g., id.* ¶¶ 75, 81, 101, 108.

Second, VNSNY makes the same flawed attack on Relator's dually eligible patient claim, ignoring the obvious (and alleged) materiality of VNSNY ignoring the Medicare/Medicaid split-billing requirements so it can double-bill under both programs. Compl. ¶¶ 82-86. That is why one senior VNSNY executive who met with Relator on the subject so readily admitted the practice is "wrong" and why a company consultant at the same meeting cautioned of potential whistleblowers and the need to "talk more with your compliance officer." *Id.* ¶¶ 87-88.

Third, VNSNY challenges Relator's home health aide supervision claim, once again under only an implied false certification theory of liability (even though the factual falsity and fraudulent inducement theories also apply). MTD 18. Even so, the allegations clearly satisfy

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That is, would the misconduct have tended to influence or been capable of influencing the government's payment decision. VNSNY cannot seriously contend the government would not find material VNSNY's submission of falsified visit information. This is especially so given the episodic payment system under which the government pays for the entire package of visits and services prescribed in the Plan of Care. Moreover, Congress specifically mandates as a condition of payment the reporting of accurate visit service time information. 42 U.S.C. § 1395fff(c).

[25] While some of these services may be covered if they are purely "incidental" to the provision of covered personal care services (MTD 17), the provision of such incidental services is not what Relator challenges here. Relator challenges VNSNY's billing for services "whose sole purpose is to enable the beneficiary to continue residing in his or her home" and which are "excluded from home health coverage." 42 C.F.R. § 409.49(d) (cited in Compl. ¶ 75). *See also* Compl. ¶¶ 77-81 (detailing VNSNY's fraud in billing for non-reimbursable custodial care services).

Escobar. As previously discussed, the payment codes on the RAP and final claims provide the same "specific representations" *Escobar* found more than adequate. *Supra* p. 14. The same is true with Relator's materiality allegations which are just the types of proof the Supreme Court identified. 136 S. Ct. at 2002-03. VNSNY does not even acknowledge the multi-million dollar payment the government has previously demanded for this very kind of misconduct, which perhaps best epitomizes how empty and mechanical its challenge is here. Compl. ¶ 91.

IV. THE COMPLAINT READILY SATISFIES RULE 9(b) WITH ITS DETAILED ALLEGATIONS OF SPECIFIC FALSE CLAIMS VNSNY SUBMITTED

A. The Required Particularity for Pleading False Claims

Under Rule 9(b), a party alleging fraud "must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). For a False Claims Act claim, this means pleading "both the particular details of a fraudulent scheme and 'details that *identify particular false claims for payment* that were submitted to the government.'" *U.S. ex rel. Kester v. Novartis Pharms. Corp.*, 23 F. Supp. 3d 242, 255 (S.D.N.Y. 2014) (quoting *U.S. ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220, 232 (1st Cir. 2004)) (emphasis in original). For the false claims piece, "the complaint must include sufficient details about the false claims such that the defendant can reasonably identify the particular false claims for payment that are at issue." *Id.* 256 (internal quotes and cite omitted). This "better fulfills the central purpose of Rule 9(b) -- providing fair notice to the defendant." *Id.*

Included among the types of detail that will satisfy the particularity requirements for pleading false claims are: identity of patient; identity of healthcare professional; date of service; services provided; reimbursement amounts; dates of claims; contents of claims; identification numbers; individuals involved in the billing; and government program involved. *Id.* at 258. "[T]his is not a checklist of mandatory requirements for every FCA complaint." *Id.* (internal quotes and cite omitted). Nor does Rule 9(b) "impose a one size fits all list of facts that must be included in every FCA complaint." *Id.* Ultimately, it is a "fact-specific inquiry" that depends on the case particulars and "the determination of how much circumstantial detail is necessary to give notice to the adverse party and enable him to prepare a responsive pleading." *Id.* (internal quotes and cite omitted). *See also Ortiz*, 2015 U.S. Dist. LEXIS 153903, *25-26 (quoting same).

VNSNY does not challenge under Rule 9(b) the sufficiency of the allegations of VNSNY's fraudulent conduct. VNSNY only challenges the particularity of the false claims it allegedly submitted. MTD 19-24. But the Complaint provides the same "who, what, where, when and how" level of detail for the claims VNSNY submitted as it does for VNSNY's fraudulent scheme. MTD 19. Most importantly, the allegations clearly provide VNSNY with reasonable notice of the false claims at issue, which is the ultimate measure of what passes Rule 9(b) muster. Nowhere in its Rule 9(b) challenge does VNSNY maintain otherwise. Nor could it given all the identifying information the Complaint provides on the alleged false claims.[26]

B. The Complaint Details With Sufficient Particularity Specific False Claims Under Relator's Plan of Care Claim

VNSNY takes its biggest leap with its challenge to the sufficiency of Relator's Plan of Care allegations, arguing they "fall well short of the types of details that courts within the Second Circuit have held to be sufficient." MTD 23. But nowhere in its attack does VNSNY take honest account of the actual detail the Complaint provides in identifying numerous false claims VNSNY submitted to the government. This includes patient identity, patient diagnosis, treatment prescribed, treatment provided, date of service, amount billed to and received from the

[26] VNSNY's Rule 9(b) challenge is particularly inappropriate given the relaxed standard that may be applied in cases like this -- even for corporate insiders -- where "the facts are peculiarly within the possession and control of the defendant." *U.S. ex rel. Lee v. N. Adult Daily Health Care Ctr.*, 2016 U.S. Dist. LEXIS 121136, *19, *25 (E.D.N.Y. 2016) (applying relaxed standard to corporate insiders, finding denial of Rule 9(b) challenge particularly appropriate "because, at this early stage in the litigation, [defendant] alone has information about the precise dates on which claims were submitted and who at [defendant] submitted them"). VNSNY is thus incorrect in its blanket assertion that "no relaxation of Rule 9(b)'s requirements is appropriate" for corporate insiders. MTD 19, n.10.

government, and why the claims were false. Compl. ¶¶ 44-45. These are the very types of identifying information the courts in this Circuit have routinely pointed to -- even in the cases VNSNY cites -- in finding the particularity requirements of Rule 9(b) satisfied.[27]

And they certainly are sufficient to give VNSNY notice of which claims are at issue. The patient identification and dates of service alone are sufficient to provide this notice. "Given that the purpose of Rule 9(b) is to ensure that a defendant has sufficient notice of the factual basis for the plaintiff's claim," VNSNY's Rule 9(b) challenge here is clearly amiss. *Columbia Cas. Co. v. Neighborhood Risk Mgmt. Corp.*, 2015 U.S. Dist. LEXIS 85014, *31 (S.D.N.Y. 2015) (Nathan, J.) (rejecting Rule 9(b) attack, finding "allegations are sufficient to put [defendant] on such notice").[28] "Indeed, [VNSNY] does not assert that it lacks sufficient information to identify the allegedly fraudulent claims it must defend against, nor could it. That is all Rule 9(b) requires."[29]

In an effort to avoid this obvious pitfall in its Rule 9(b) challenge, VNSNY claims there are no allegations that VNSNY failed to follow the "various mechanisms for addressing any relevant deviations" from the Plan of Care. MTD 23-24. VNSNY does not explain what, if anything, this charge has to do with Rule 9(b). More importantly, it brazenly guts from the Complaint the core allegation surrounding VNSNY's misconduct here -- VNSNY's unilateral decision to ignore the doctor's critical care orders to maximize profits at the expense of patient health and well-being. *Supra* pp. 4-6 (citing Compl. ¶¶ 27-48, 62). As the Complaint makes clear in painstaking detail, there is no "mechanism" for engaging in this kind of "deviation."[30]

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[27] *See, e.g., Kester*, 23 F. Supp. 3d at 258 (pointing to patient identity, date of service, services provided, reimbursement amounts, why claim was false) (cited by VNSNY); *U.S. ex rel. Arnstein v. Teva Pharm. USA, Inc.*, 2016 U.S. Dist. LEXIS 22554, *41-42 (S.D.N.Y. Feb. 22, 2016) (same, quoting *Kester*); *U.S. ex rel. Mooney v. Americare, Inc.*, 2013 U.S. Dist. LEXIS 48398, *12 (E.D.N.Y. 2013) (same) (cited by VNSNY); *Lee*, 2016 U.S. Dist. LEXIS 121136, *23 (same) (cited by VNSNY); *Ortiz*, 2015 U.S. Dist. LEXIS 153903, *27-29 (same).

[28] This case is thus far removed from the cases VNSNY cites to support its Rule 9(b) challenge. None of them involved the level of detail this Complaint has in identifying the alleged fraudulent claims. They involved complaints with no identifying information at all. *See* MTD 18-23 (citing *U.S. ex rel. Ladas v. Exelis, Inc.*, 824 F.3d 16, 27 (2d Cir. 2016) (complaint "does not include the specifics of any claims submitted"); *Wood ex rel. U.S. v. Applied Res. Assoc.*, 328 F. App'x 744, 750 (2d Cir. 2009) (complaint "does not cite to a single identifiable record or billing submission they claim to be false"); *U.S. ex rel. Scharff v. Camelot Counseling*, 2016 U.S. Dist. LEXIS 133292, *21 (S.D.N.Y. 2016) (complaint "makes no allegations that relate to the submission of any false claim"); *U.S. ex rel. Blundell v. Dialysis Clinic, Inc.*, 2011 U.S. Dist. LEXIS 4862, *35 (N.D.N.Y. 2011) (complaint "fails to cite to a single fraudulent record or billing submission"); *U.S. ex rel. Chen v. EMSL Analytical, Inc.*, 966 F. Supp. 2d 282, 302 (S.D.N.Y. 2013) (complaint "[n]owhere . . . identif[ies] a particular false claim"); *U.S. ex rel. NPT Assoc. v. Lab Corp. of Am. Holdings*, 2015 U.S. Dist. LEXIS 155601, *17 (S.D.N.Y. 2015) (complaint did not allow defendant '"to reasonably discern which of the claims [] submitted are at issue'") (quoting *Kester*).

[29] *U.S. ex rel. Forcier v. Computer Sciences Corp.*, 2016 U.S. Dist. LEXIS 59907, *25-26 (S.D.N.Y. 2016) ("Rule 9(b) does not call for Plaintiffs to plead every conceivable fact about the claims they allege were fraudulent;" only "fair notice" and "adequate information to frame a response."). *See also Kester*, 23 F. Supp. 3d at 265 (allegations sufficient "to allow [defendant] to figure out which claims [plaintiff] contends were false"); *Arnstein*, 2016 U.S. Dist. LEXIS 22554, *45-46 (allegations sufficient for defendant "to identify those false claims"); *Ortiz*, 2015 U.S. Dist. LEXIS 153903, *26 (allegations sufficient to allow defendants to "reasonably identify particular false claims") (internal quotes and cite omitted); *Lee*, 2016 U.S. Dist. LEXIS 121136, *24-25 (same).

C. The Complaint Details With Sufficient Particularity Specific False Claims Under Relator's Falsified Visit Claim

VNSNY's Rule 9(b) attack on Relator's falsified visit claim suffers from the same essential defect -- the Complaint provides reasonable notice of the relevant fraudulent claims. VNSNY tries to get around this by broadly asserting there is not "even a scintilla of detail" identifying any of these claims. MTD 21. Once again, VNSNY conveniently ignores the very allegations it finds lacking. This includes all the detail laid out in the many nurse-specific examples of falsified visits, including nurse identity, patient identity, date of service, address of visit, duration of visit, time of visit, their inclusion in claims for payment to the government, and the basis for the alleged fraud. Compl. ¶¶ 70-71. As discussed above, this is the same kind of identifying information the courts regularly rely on in finding Rule 9(b) satisfied.

VNSNY tries to prop up its challenge with the additional sleight of hand of trying (yet again) to transform the allegations of falsified visits into a mere "failure to obtain patient signatures or telephone call confirmations." MTD 21 (citing *Scharff*). As previously discussed,

[30] For this same reason, VNSNY is equally disingenuous with its corresponding lament on the Complaint's supposed failure to allege whether this "deviation" changed the amount VNSNY would have billed and the government would have paid had VNSNY followed the Plan of Care. MTD 23-24. As the Complaint makes clear, the comparative billing and payment calculation VNSNY calls for is unwarranted because had the government been aware of VNSNY's intended and actual Plan of Care violations it would have withheld payment altogether. *See, e.g.*, Compl. ¶¶ 63, 101, 108. At the very least, it certainly would have tended to influence or been capable of influencing the government's payment decision. To the extent VNSNY's proffered damages inquiry is even appropriate on a motion to dismiss, this *Escobar* materiality question is the only threshold that needs to be crossed.

that is not what Relator is challenging. *Supra* pp. 7, 17. Thus VNSNY's reliance on *Scharff* and the "sloppy adherence to internal verification requirements" at issue there have no application here. As the court emphasized in reaching its decision, the complaint alleged "[a]t most . . . a series of seemingly unrelated practices . . . that reflect an inattention to detail." 2016 U.S. Dist. LEXIS 133292, *10. There were no allegations that the defendant requested reimbursement "for services [] not actually provided." *Id.* But that is exactly what Relator has alleged with its three pages worth of detailed examples -- backed by VNSNY's official reports -- of visits billed to the government that did not occur or last long enough to provide any meaningful care. *Supra* p. 7.

D. The Complaint Details With Sufficient Particularity Specific False Claims Under Relator's Home Health Aide Claim

With its Rule 9(b) challenge to Relator's home health aide claim, VNSNY again feigns significance from the episodic versus fee-for-service nature of the payment system. MTD 22. As previously discussed, there is none, particularly as it relates to VNSNY billing the government for services it did not provide. *Supra* p. 6. That is exactly what VNSNY has done by billing Medicare for covered personal care services when they were actually non-covered custodial care services. Compl. ¶¶ 75-81. In claiming the Complaint "provides no details" on these alleged false claims (MTD 22), VNSNY again disregards the numerous examples which detail the patient identity, dates of service, number of hours of service misreported and billed, and why the claim is false. Compl. ¶¶ 77-78. Given these charges would appear in "line-item detail" on the associated final claim for payment to Medicare, as VNSNY acknowledges (MTD 4), VNSNY cannot contend it lacks reasonable notice of the relevant claims at issue here. That is the ultimate Rule 9(b) question and one that VNSNY has consistently refused to address.[31]

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[31] For the unsupervised visits claim, the Complaint likewise alleges for several patient-specific examples the patient identity, number of missed supervision visits, and the precise internal VNSNY report from which this information derives. Compl. ¶ 90. With respect to the dually-eligible visits claim, the Complaint does not provide this kind

CONCLUSION

For the reasons set forth herein, Relator respectfully requests that the Court deny VNSNY's motion to dismiss the Complaint.[32]

Dated: December 23, 2016

Respectfully submitted,

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case-specific identifying information. However, a relaxed Rule 9(b) standard should be applied given the specific application of the alleged split-billing scheme is "peculiarly within the possession and control" of VNSNY. *Lee*, 2016 U.S. Dist. LEXIS 121136, *19. In addition, it is "based on factual information that makes the inference of culpability plausible." *Id.* This is particularly so given the allegations of six years of aggregated data on VNSNY's disproportionate Medicaid billings, the 2013 audit confirming the scheme, and the admission by one company executive that the billing scheme is "wrong" and has been going on for years. Compl. ¶¶ 85-88.

[32] Relator respectfully requests oral argument on this motion and the right to amend the Complaint to the extent the Court finds any of the allegations lacking.

CERTIFICATE OF SERVICE

I certify that on December 23, 2016, I caused a true and correct copy of the foregoing document to be served upon all counsel of record via the CM/ECF system. I also certify that a true and correct copy of the foregoing is being served via electronic mail to:

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